No. 80-419

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1980

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STATE OF ARIZONA

Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, AND PIMA FOUNDATION FOR MEDICAL CARE,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT BRIEF FOR RESPONDENTS

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RESTATEMENT OF QUESTION PRESENTED

On Petitioner's motion for partial summary judgment the undisputed facts established an agreement among health care providers who are members of a Medical Foundation that (1) each would charge its individual customary fee, but (2) with respect to patients covered by health insurance endorsed by that Medical Foundation each would accept as payment in full the amount paid by that insurance and not to try to recover from the patient any difference between the insurance payment and the fee billed if the fee was higher than the maximum level of reimbursement established by the Foundation. Accordingly, it is submitted that the question presented must be restated as follows:

Did the Court of Appeals err in deciding that the agreement among Foundation members was not properly characterized by Petitioner as horizontal "price-fixing" (a *per se* violation of Section 1 of the Sherman Act) and that the action should proceed to trial to determine the economic effects of that agreement?

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT BRIEF FOR RESPONDENTS

COUNTERSTATEMENT OF THE CASE

Proceedings Below

Contrary to Petitioner's claim, it did not await "*completion* of relevant discovery" to move for partial

summary judgment on the issue of liability.[1] Only two depositions have been taken by Petitioner.[2] Respondents objected in the District Court to Petitioner's effort to obtain summary judgment before Respondents had adequate discovery.[3] Respondents have taken no depositions as yet and Maricopa County Medical Society and Pima Foundation for Medical Care have not even initiated their discovery. The parties have filed affidavits in the District Court which conflict as to numerous material facts.[4]

The District Court's Decision

The District Court recognized the insufficiency of the undisputed facts in the record to support Petitioner's motion for partial summary judgment on the issue of liability by denying it on June 5, 1979 "with leave to file a similar motion based on additional evidence if appropriate."[5] The District Court's determination followed a two-pronged analysis. First, the court refused to apply

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[1]Pet. Br. at 12; emphasis added. Petitioner's motion (J.A. 40) was filed November 20, 1978, *preceeding*: (i) Respondents' answers to Petitioner's first set of requests for admissions and first set of interrogatories (dated December 4, 6 and 13, 1978); (ii) Petitioner's answers to Respondent Maricopa Foundation's first set of interrogatories and first set of demands for the production of documents (dated November 30, 1978); (iii) Petitioner's supplemental answers to Respondent Maricopa Foundation's first set of discovery requests (dated December 6 and 21, 1978 and July 13, 1979); and (iv) the deposition of Anthony D. Mitten (taken November 22, 1978; J.A. 297, 305).

[2]*I.e.*, the Deposition of Mary Gerdonics, filed November 20, 1978 (J.A. 34); and the Deposition of Anthony D. Mitten, filed December 27, 1978 (J.A. 297, 305).

[3]J.A. 484–88.

[4]See, *e.g.*, J.A. 31, 74, 88, 309, 332, 335, 404, 529, 532, 535, 538; C.R. 14, 37.

[5]Pet. App. D at 48.

blindly and mechanically the *per se* test demanded by Petitioner, recognizing that not all joint conduct should be characterized as a *per se* violation. The court cited *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977) and *General Glass Co. v. Globe Glass & Trim Co.*, [1978-2] Trade Cas. (CCH) ¶ 62,231 (N.D. Ill. 1978).[6]

The second prong of the opinion recognized that, because the case concerns the medical profession, the court should give Respondents the opportunity to show that the challenged conduct promoted improvement of professional services to the public.[7] It relied upon *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 778 n.17 (1975), *National Society of Professional Engineers v. United States*, 435 U.S. 679, 686 (1978), *Boddicker v. Arizona State Dental Association*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977), and *Mackey v. National Football League*, 543 F.2d 606 (8th Cir. 1976), *cert. dismissed*, 434 U.S. 801 (1977). The District Court found that on the record before it on Petitioner's motion for partial summary judgment, Respondents' activities were more properly tested by a Rule of Reason analysis than by the rigid *per se* test for liability which would follow from accepting Petitioner's characterization of what it incorrectly claimed to be the undisputed material facts.[8]

The District Court subsequently denied Petitioner's motion for summary judgment and permanent

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[6]The District Court did not rule that *Continental T.V.* "established" a trend away from a *per se* approach, as claimed by Petitioner at page 12 of its Brief.

[7]Contrary to Petitioner's claim at page 12 of its Brief, the District Court did *not* intimate that *per se* analysis never applied to professionals.

[8]Pursuant to U.S.D.C., D. Ariz. R. 11(h), Respondents placed many of what Petitioner calls "undisputed material facts" in dispute. J.A. 123.

injunction on August 6, 1979, along with Petitioner's motion for reconsideration of the District Court's June 5, 1979 Memorandum and Order.[9] On August 8, 1979, the District Court amended its June 5, 1979 order to certify for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) its denial of Petitioner's motion for partial summary judgment.[10] The only determination of the District Court to be reviewed on this writ is application of the Rule of Reason to the challenged conduct on a motion for partial summary judgment based on a record containing disputed material facts.[11]

The Court of Appeals' Decision

On November 19, 1979, the Ninth Circuit Court of Appeals issued an order which affirmed the pertinent District Court rulings and dissolved a limited stay which the Ninth Circuit issued pending determination of the appeal, District Judge Larson dissenting.[12] It stated that "[w]ith respect to the interlocutory appeal . . ., we conclude

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[9]Pet. App. E.

[10]Pet. App. F at 50.

[11]The August 6, 1979 denial of Petitioner's motion for summary judgment and permanent injunction was not appealed and is not before the Court. Petitioner never sought an evidentiary hearing with respect to its motion for preliminary injunction, but it appealed the order vacating the temporary restraining order on July 19, 1979. J.A. 482. The Ninth Circuit Court of Appeals' affirmance of that order is not before the Court on this writ.

Also, the District Court's earlier ruling denying Respondents' motion to dismiss based upon the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1977), was not appealed and is not before the Court. *Arizona v. Maricopa County Medical Society*, 643 F.2d 553, 559 n.7 (9th Cir. 1980).

[12]Pet. App. C at 37. Petitioner does not challenge that portion of the Ninth Circuit's determination on this writ.

that *on the present state of the record* the [Respondents'] conduct should not be considered a per se violation of the Sherman Act, 15 U.S.C. § 1" and thus affirmed the denial of partial summary judgment.[13]

The Ninth Circuit's opinion, filed March 20, 1980, explained that, given the facts in the record on appeal, the court could not rule that the District Court erred in denying Petitioner's motion for partial summary judgment. The majority initiated its analysis by stating: "We must approach this appeal mindful that the Supreme Court has made it clear that the determination whether an agreement violates the Sherman Act turns on its 'impact on competitive conditions.' *National Society of Professional Engineers v. United States*, 435 U.S. 679, 688 . . . (1978). . . . The key, to repeat, is the agreement's impact on competition."[14]

The decision reemphasized that the *undisputed* facts adduced in limited pretrial discovery were inadequate to support a blind characterization of the challenged conduct as "price-fixing" subject to the *per se* standard:

> The State of Arizona insists that [Respondents'] practice . . . constitutes an arrangement without any redeeming virtue that suppresses and destroys competition and is thus unreasonable per se. The difficulty with [Petitioner's] position is that *this record reveals nothing about the actual competitive effects of the challenged arrangement* nor do the authorities, primary or secondary, afford assurance concerning its competitive impact. In truth, we know very little about the impact of this and many other arrangements within the health care industry.

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[13] *Id.*; emphasis added.

[14] 643 F.2d at 555–56.

> This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement.[15]

Judges Sneed and Kennedy looked to *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) for guidance. Citing to it, Judge Sneed noted "that whether to classify something as ' "*per se* price-fixing" . . . will often, but not *always*, be a simple matter.' "[16] He described some of the factual uncertainties which need clarification at trial:

> The issue whether to so classify the price schedules in this case is by no means "a simple matter." In addition to the uncertainties already referred to, we do not know how health insurers such as Blue Cross fix their fee schedules in the relevant geographical area or whether the fees they offer exceed the [Respondents'] maximum fees. *We are not informed by the record of the identity of, or the role played by, the various institutional components that compete in the relevant market.* One may *guess* that doctors, both within and without the FMC structure, insurance carriers, hospitals, and perhaps HMOs, operate within the market; *nonetheless, the record reveals nothing about the nature and extent of the competition between them. This makes it impossible to evaluate the pro- and anti-competitive aspects of a given feature of the total structure,* although these aspects must be weighed together in determining whether a per se rule, or even the Rule of Reason, should brand the questioned feature illegal.[17]

The majority opinions note repeatedly that "[h]ere the novelty of the market or markets *and the inadequacy of*

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[15] *Id.* at 556; emphasis added.

[16] *Id.* at 558; emphasis in original.

[17] *Id.*; emphasis added.

the record make an inquiry into the affected areas of competition *essential*"[18] and Judge Sneed concluded, "To

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[18]*Id.* at 558 n.5; emphasis added. See also, *e.g.*, *id.* at 557: ("We are, however, simply not prepared to brand the [Respondents'] conduct as 'price-fixing' and thus a per se violation of the Sherman Act on the basis of an unsupported *belief* that fee enhancement is the likely consequence of the [Respondents'] maximum fee arrangement.") (emphasis in original); *id.* at 556–57: ("Approached in this manner, the weakness of [Petitioner's] suggestion that a per se rule be employed here becomes apparent. To assume that the arrangement in question wrongfully increases fees requires the further assumption that the FMCs are but devices to enable the member doctors to capture a greater share of potential monopoly profit, which their monopoly power makes available, than otherwise would be possible. *This is an assumption we are not prepared to make on the basis of the record before us.*") (emphasis added); and *id.* at 556: ("[W]e lack baselines by which could be measured the distance between the present supply and demand functions and those which would exist under ideal competitive conditions.")

Judge Kennedy expressed the same factual concerns in his concurring opinion:

> I agree with my Brother Sneed that we know too little about the effects on competition produced by the practices here in question to brand them per se violations of the Sherman Act at this point. "It is only after considerable experience with certain business relationships that courts classify them as *per se* violations . . ." *United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-08 . . . (1972). *We lack that experience in judging the maximum reimbursement schedules present here. . . .*
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> * * *
>
> Per se rules should be derived from considerations of economic impact in particular cases illustrating the category of prohibited acts, and *therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules.*
>
> This is not to suggest, however, that I have found these reimbursement schedules to be per se proper, *that an examination of these practices under the rule of reason at trial* will not reveal the proscribed adverse effect on competition, or that this court is foreclosed at some later date, *when it has more evidence*, from concluding that such schedules do constitute per se violations.

Id. at 560; emphasis added.

affix the per se label to [Respondents'] conduct is, however, once more *to substitute an unsupported belief for proper proof.*"[19]

Petitioner simply failed to present sufficient undisputed facts to justify *per se* treatment of Respondents' challenged conduct on a motion for partial summary judgment (especially since professionals had only recently been brought within the purview of Section 1 of the Sherman Act).[20] The Circuit Court made it clear that Petitioner will have its opportunity to present sufficient evidence (if it exists) to establish liability *after* the parties have the opportunity to complete discovery.[21]

The Nature of Respondent Foundations for Medical Care

Respondents Maricopa and Pima Foundations are non-profit Arizona corporations established to provide competitive alternatives to utilization of closed panel prepaid health insurance plans.[22] Respondents act as the agents of participating insurers or self-insured groups[23]

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[19]*Id.* at 557; emphasis added.

[20]*Id.* at 556; citing *Goldfarb v. Virginia State Bar*, 421 U.S. at 785–88.

[21]See, *e.g.*, 643 F.2d at 558 n.5 (majority opinion) and 560 (J. Kennedy, concurring).

[22]J.A. 31 ¶ 2, 74 ¶¶ 3 & 4.

[23]Contrary to Petitioner's unsupported assertions in note 6 of its Brief, when a major employer such as Motorola, Inc. makes payments on Foundation endorsed insurance, it is accurate to refer to it as the insurer. Petitioner concedes those employers simply eliminate the insurance company as the underwriter of the actuarial risk and assume that risk themselves.

and as such they review the medical necessity and propriety of treatment rendered and, to the extent appropriate, pay the claim.[24]

Foundation member health care providers agree to accept as payment in full for patients covered by Foundation endorsed insurance the *maximum* level of reimbursement from the insurer for services rendered if they bill *more* than that level (and are paid *less* than that level if they bill less).[25] What the member health care provider is paid by the Foundation endorsed insurance may not fully compensate him or her for the services provided, but he or she cannot collect any more from the covered patient. On the other hand, non-members are free to obtain directly from the patient the difference between the maximum reimbursement paid and the amount of the bill.[26]

The District Court recognized that "the doctors who agree to participate in the foundation-approved plans are free to set the prices they charge their patients."[27] Physician members of a Foundation specifically agree that "participating membership in the foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any

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[24]J.A. 31 ¶ 2, 76 ¶ 9.

[25]J.A. 31 ¶ 3, 76 ¶ 10. Petitioner seeks to cloud the effect and intent of the challenged conduct by relying upon documents which call Foundation maximum reimbursement levels "uniform fee schedules". It is a fact that Foundation members are bound by their agreements with the Foundation not to use the maximum reimbursement levels to determine billings to patients. J.A. 31 ¶ 3, 514 ¶ 14. They are not "fee schedules" as that term is commonly understood or used in antitrust analysis.

[26]J.A. 76-77 ¶¶ 10-12.

[27]Pet. App. D at 39.

patient."[28] The members of Maricopa Foundation no longer vote on changes in the maximum reimbursement levels to be paid, which are established entirely by the Foundation's Board of Trustees.[29] The county Medical Society and the Foundation in that county have many members in common, but Respondent Foundations currently have no formal relationship with county Medical Societies.[30]

The agreements a Foundation enters into with insurers concern only the Foundation endorsed insurance they underwrite. Insurers are not compelled to write Foundation endorsed insurance, and therefore Foundations have no power to fix prices for medical services paid for by insurers. The insurers are free to write any other

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[28]J.A. 31 ¶ 3, 514 ¶ 14.

[29]The 1980 revision to Maricopa Foundation's by-laws gives its Board of Trustees power "to adopt reimbursement schedules for medical services, which when adopted by a majority vote of the Board of Trustees shall be binding upon all participating and cooperating members, of this corporation while, and so long as, they are participating and cooperating members in good standing of this corporation." App. A, By-Laws of the Maricopa Foundation for Medical Care, Revised as of January 25, 1980, at A-6.

[30]Petitioner erroneously states that the Maricopa County Medical Society is the Maricopa Foundation's "parent corporation." Pet. Br. at 2 n.1. While Maricopa Foundation was incorporated in 1969 by members of the Medical Society, the only structural link between the two corporations thereafter was a Maricopa Foundation by-law which provided that each person serving on the Medical Society's Board of Trustees automatically became an administrative member of the Medical Foundation. J.A. 189 ¶ 3; C.R. 7(b), Ex. MF-122 at 2. On January 25, 1980, the voting membership of Maricopa Foundation approved a revision of the by-laws of the Foundation. App. A at A-1. It eliminated the "administrative member" class of membership, removing that link. The Foundation's Board of Trustees is elected by the participating membership, not the county Medical Society. The consent judgment entered by Pima County Medical Society eliminated the links between it and Pima Foundation.

insurance on any other terms and may offer as alternatives to the same insureds Foundation endorsed and non-Foundation endorsed plans. While Petitioner attempts to create the impression that the Foundations are dominating forces in the "pre-paid health care market", in fact they are but one of many alternatives competing to provide health care.[31]

With respect to the Foundation endorsed plans, insurers agree to cover at least those medical services described in a Foundation's minimum standards and to reimburse health care providers for services rendered to insured patients in accordance with their usual and customary fees charged for such services but not to exceed the maximum level of reimbursement established by the Foundation, except at the insurer's discretion.[32]

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[31]*Cf.* J.A. 494–97. In its Brief at note 4 on page 5, Petitioner casually opines that certain ratios set out in a Foundation document dated October 11, 1974 "would indicate that the Maricopa Foundation had approximately 63 percent of the pre-paid health care market compared to 16 percent for health maintenance organizations and 21 percent for other indemnification plans." The cited letter indicates nothing of the kind. It concerns an informal survey of fewer than 13,000 people who worked for employers providing *multiple* options for health care. It simply points out that given free choice, they preferred the Foundation plan. C.R. 7(b), Ex. MF-90 at 2 ("As you can see, the Foundation is in most cases the choice of the individual subscriber.") A survey of this small, unrepresentative sample cannot establish competitors' shares of a "pre-paid health care market" for Maricopa County estimated to consist in 1974 of at least 1,500,000 persons. C.R. 68, Ex. A at 462. Petitioner's attempt to use the October 11, 1974 report as a market-share analysis is disingenuous. In 1979 Maricopa Foundation only claimed to insure about 100,000 lives in 48 groups. J.A. 407.

Nowhere in the record are there undisputed facts concerning the various competitors' shares of a health care market.The Ninth Circuit majority opinion found the record too inadequate to elucidate even the *identity* of the competitors in the market, much less their relative market shares. *Maricopa County Med. Soc'y*, 643 F.2d at 558 (quoted *supra* at 6).

[32]J.A. 129 ¶¶ 21–22.

The Foundations' use of defined dollar limits, rather than a variable level based on usual and customary fees, to determine maximum insurance reimbursement levels is essential to the concept and operation of Foundation insurance plans. The marketability of Foundation endorsed health insurance depends in large part on consumers' desire to purchase a health plan, such as Foundation endorsed insurance, which will pay 100% of physicians' charges for any given service.[33] Maricopa Foundation estimated when this action was brought that it had saved patients and their insurers over $6 million in medical fees;[34] Petitioner does not dispute that those reductions in medical costs have occurred.[35]

Patients insured by Foundation endorsed insurance plans need not go to Foundation members for treatment. They are free to enlist the services of any physician of their choice.[36] All health care providers were and are free to bill as they like and are treated the same whether or not they belong to a Foundation. Any physician treating a patient covered by Foundation endorsed insurance will be paid under the insurance in the same manner (*i.e.*, up to the Foundation's maximum level of reimbursement). Unlike *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 49 U.S.L.W. 4672 (U.S. June 15, 1981) and *Chalmette General Hospital, Inc. v. Louisiana Health Service & Indemnity Co.*, No. 78-1875 (E.D. La., filed June 9, 1978), there is no dual system of reimbursement at issue in this case.

In addition to free choice of physicians, the benefits to Foundation insured patients include the possibil-

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[33]J.A. 529 ¶ 3, 538 ¶ 3.

[34]J.A. 408.

[35]Maricopa Foundation estimates at this time that the savings in medical fees are well in excess of $8 million.

[36]J.A. 32 ¶ 4, 76 ¶ 10.

ity of lower insurance premiums (due to the savings insurers realize on payments to providers), assurance that if a Foundation provider member is used, the insured will not have to pay any difference between what the health care provider bills and what the insurance will reimburse (less any deductible in the insurance plan)[37] and knowledge that the health care provider will be discouraged from performing unnecessary treatment because a qualified peer will review the treatment performed to determine if it is medically necessary or appropriate.[38] Thus the Foundations offer a health care service different from that which individual physicians or individual insurers could separately provide to the public.

Petitioner Has Failed to Show Price-Fixing or Fee Uniformity

Petitioner failed to adduce on its partial summary judgment motion undisputed facts to support its price-fixing claims. Petitioner apparently relies solely upon the existence of Maricopa and Pima Foundations and their past use of relative value schedules and conversion factors voted on by their membership to establish maximum reimbursement levels.[39]

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[37]J.A. 76 ¶ 10, 129 ¶ 22.

[38]J.A. 31 ¶ 2, 76 ¶ 9.

[39]Contrary to Petitioner's assertion (Pet. Br. at 4), the record does *not* demonstrate that the Foundations consult with different medical specialty associations to determine prices charged by their members and use that information to formulate fee schedules. The Foundations have only requested advice from representatives of specialty groups concerning changes which might be necessary to make Foundation maximum reimbursement levels for procedures rendered by member physicians more equitable. *See* J.A. 84 ¶ 11; C.R. 7(a), Ex. PF-182; C.R. 7(b), Ex. MF-27 through MF-46; *see also*, J.A. 163 ¶ 44, 200 ¶ 44.

Maricopa Foundation's current standards include maximum reimbursement schedules of benefits which use neither relative values nor conversion factors.[40] That new schedule of benefits is an administrative document which is not circulated or distributed to the Foundation's membership. The Foundation does not provide a tabulation of its maximum reimbursement levels to its member health care providers. Pima Foundation took similar action in 1980 to establish maximum reimbursement levels without using conversion factors and relative values.

Petitioner itself currently prepares and circulates both relative value schedules and conversion factors used to determine payments by Arizona to physicians for their services in, *inter alia*, workmen's compensation cases.[41] In many instances, Petitioner's maximum reimbursement levels have been higher than the Foundations'.[42]

No Evidence Supports Petitioner's Claim That the Foundations' Maximum Reimbursement Levels Were Intended to Act as Uniform Fee Schedules or Raise Physicians' Fees

Petitioner did not present undisputed factual support for its assertion on its summary judgment motion that the Foundations' maximum levels of insurance reimbursement either are intended to be uniform schedules of fees physicians should bill their patients or have op-

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[40]App. B, Standards for Foundation-Endorsed Group Insurance Programs, as Amended April 1, 1980.

[41]J.A. 472–76 (Int. 22–25).

[42]J.A. 94 ¶ 8.

erated as such.[43] In fact, the maximum levels of reimbursement adopted by the Maricopa and Pima Foundations are substantially different.[44]

Petitioner states that "[t]he *ostensible* purpose of the foundation fee schedules is to establish 'the maximum level of reimbursement' that a foundation member may receive for services performed under a foundation-endorsed pre-paid health plan."[45] The record establishes that this is the *actual* and *only* purpose of the 'fee schedules' Petitioner attacks: "The sole purpose for which relative value schedules and conversion factors have been prepared or used by the Maricopa Foundation is in determining the maximum reimbursable levels of compensation for medical services provided to patients insured under Maricopa Foundation endorsed medical health in-

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[43]Petitioner claims that "[t]he record here is clear that the purpose of the letters, polls and meetings among the foundations and their members *was to set one price* for any given service." Pet. Br. at 28 n.35; emphasis added. However, that claim was disputed by Respondents on Petitioner's partial summary judgment motion. First, the only evidence of fees actually charged shows a bell curve distribution of charges, not "one price". J.A. 498-501. Secondly, the questioned conduct was used by the Foundation board of trustees solely to establish equitable conversion factors and relative values. They had to be sure that the Foundations' maximum reimbursement levels were not so low in relation to the members' current usual fees that the members would resign or refuse to renew their memberships rather than accept those maximum reimbursement levels as payment in full. *See, e.g.*, J.A. 88 ¶ 3, 127 ¶ 15, 163–64 ¶¶ 44–54, 200–02 ¶¶ 44–54, 229 ¶ 157, 239 ¶ 192, 261 ¶¶ 281–82, 521–22 ¶¶ 58 & 63; C.R. 7(a), Ex. PF-182; C.R. 7(b), Ex. MF-27 through MF-46; compare J.A. 333 ¶¶ 3–5, 335–36 ¶¶ 3–5, 530 ¶ 4, 532 ¶ 3, 535 ¶ 3, 538 ¶ 4.

[44]*Compare* J.A. 185 ¶ 413 *with* J.A. 268 ¶ 304.

[45]Pet. Br. at 5; emphasis added.

surance plans."[46] The undisputed facts simply do not establish any other purpose or use, whether nefarious or noble, for the Foundations' maximum reimbursement levels.

Petitioner boldly states that since "conversion factors apply to all medical procedures[,] . . . an increase in the conversion factors therefore results in an across-the-board increase in the doctors' prices."[47] However, there is no evidence in the record of any relationship at all between changes in the fees physicians in Maricopa and Pima counties charge their patients and changes in the Foundations' maximum reimbursement levels. The District Court could not tell from the record whether the Foundations' maximum reimbursement levels were increased by the Foundations *because* medical fees previously had gone up (as Respondents assert) or whether their increase by the Foundations *caused* medical fees to go up (as Petitioner asserts).[48]

Petitioner describes in detail in its Brief one specialty group's input into a Foundation's decision whether to change its "surgery" conversion factor. Nowhere in

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[46]J.A. 88 ¶ 2. *See also*, J.A. 32 ¶ 4, 75 ¶ 8, 76 ¶ 10, 78 ¶ 16, 82 ¶ 1, 125 ¶ 8, 128 ¶ 18, 129 ¶ 22, 152 ¶ 26, 159 ¶ 18, 208 ¶ 78, 309 ¶ 2, 496, 514 ¶ 14, 516 ¶ 37.

[47]Pet. Br. at 8.

[48]For example, Petitioner claims at page 7 of its Brief that ". . . once the fee schedules are established . . . foundation members revise their prices so that some 85 to 95 percent charge prices at or above those established by the fee schedules." There is absolutely no evidence of any causal relationship between Foundation maximum reimbursement levels and physicians' fees.

Petitioner's lopsided recounting[49] does Petitioner demonstrate that any doctor's fee changed as a result of the Foundation's decision to change its surgery conversion factor from $9.50 to $10.50. The record simply does not support Petitioner's claim that doctors raised their fees in response to conversion factor changes.

Similarly, the record contains absolutely no evidence that Foundation increases in the relative value it used for any procedure resulted in an increase in the fees physicians actually charged to perform services.[50] Petitioner only cites prevailing fees *preceeding* relative value increases.

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[49]As Petitioner would tell it, the Maricopa Foundation Board of Trustees raised the surgery conversion factor to $10.50 from $9.50 in spite of input from plastic surgeons and otolaryngologists. The Board, however, considered *all* surgical specialties in establishing the new conversion factor. Other specialties also transmitted their views to the Board.

The president of the Phoenix Urological Society stated, "I think without reservation one could say that your present charge of 9.5 dollars per unit is less than what most physicians are presently charging." C.R. 7(b), Ex. MF-6. He also stated that "most of the physicians were 10 to 11 with a few at 12, and only one physician was 9.5." *Id.* A representative of the Phoenix Obstetrical and Gynecological Society requested an increase in the factor to $10.50: "This would represent approximately a modest 5% increase each year for 1976 and 1977. Actual charges in the community now equal a conversion factor of $12.00 to $12.50 per unit." *Id.*, Ex. MF-8. An internist requested $12.50 (*id.*, Ex. MF-10) and four gastrointestinal specialists suggested that their procedures be reclassified as "medical", and thus subject to an $11.00 conversion factor (*id.*, Ex. MF-11). Of the otolaryngologists whose responses are in the court record, three requested a factor of $10.50 or greater (*id.*, Ex. MF-12, MF-13, MF-17 & MF-27).

Faced with this broad range of input, the Foundation board in good faith chose a conversion factor which certainly was not above prevailing fees.

[50]Compare Pet. Br. at 10–11 with J.A. 495–497.

The marketability of Foundation endorsed insurance depends upon its price being competitive with other health insurance.[51] Since increases in maximum reimbursement levels cause the insurers to make upward adjustments to insurance premiums,[52] the market price of health insurance is an effective restraint upon increases in maximum reimbursement levels. A Foundation cannot raise maximum reimbursement levels above those insurers use for non-Foundation insurance because no insurer would underwrite Foundation endorsed plans with such non-competitive rates.

The Foundations Did Not Adopt Maximum Reimbursement Levels Above the Average and Median Fees Prevailing in the Community

Petitioner claims that Maricopa Foundation's maximum reimbursement levels were above the prevailing average and median fees charged by physicians as evidenced by the Foundation's own survey.[53] The facts once again do not support Petitioner's assertion. The fee survey to which Petitioner refers was a *statewide* survey conducted by the Arizona Medical Association, not the Maricopa Foundation.[54] The figures include fees charged by rural Arizona medical practitioners[55] as well as the

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[51]J.A. 530 ¶ 6, 539 ¶ 7.

[52]*See* Lynk, *Regulatory Control of the Membership of Corporate Boards of Directors: The Blue Shield Case*, 24 J. Law & Econ. 159, 161 (1981) (hereinafter referred to as "Lynk").

[53]Pet. Br. at 7 & n.7.

[54]J.A. 248 ¶ 230; C.R. 7(b), Ex. MF-71 at 2.

[55]Petitioner would have the Court ignore the obvious fact that small town general practitioners charge less for services than more specialized and often better-trained and equipped metropolitan area physicians.

lower fees prevailing in Tucson (Pima County) as compared to Phoenix (Maricopa County).[56]

The 1977 increase in Maricopa Foundation's relative values for coronary bypass procedures is an example of the error in Petitioner's assumption.[57] The maximum allowable reimbursements were increased to levels *below* the fees prevailing in the county. The Maricopa Foundation Physicians Review Committee recommended that maximum reimbursement levels for single, double and triple coronary bypass procedures be increased to $2000, $2300 and $2600 respectively. The recommendation included a tabulation showing that average fees for those procedures in the Phoenix metropolitan area were $2000, $2353 and $2685.[58] Despite that recommendation, the Foundation Board of Trustees only increased the maximum reimbursement levels to $1900, $2137.50 and $2375 respectively.[59] Respondents seek an opportunity to prove at trial that reimbursement schedule changes such as these *contain* health care costs, rather than raise them.

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[56]The then-prevailing Pima Foundation conversion factors were all less than the corresponding Association survey average figures. *Compare* J.A. 248 ¶ 230 *with* J.A. 178 ¶ 364. Significantly, the 1976 conversion factors Petitioner attacks set a value of $12.00 for anesthesiology, a value *below* the $12.30 prevailing average indicated by the Association's survey. C.R. 7(b), Ex. MF-71 at 2. Inasmuch as anesthesiology is primarily a "big-city" specialty, the Association's "anesthesiology" average better represented the " 'prevailing average or median fee charged by physicians [*i.e.*, anesthesiologists] in the [Phoenix metropolitan] community' " than did the Association's figures relating to the more geographically dispersed "medicine" classification. Pet. Br. at 7 n.7; quoting Br. in Opp. at 4.

[57]Nevertheless, Petitioner cites the coronary bypass procedures' relative value increases to support its claim. Pet. Br. at 12.

[58]C.R. 7(b), Ex. MF-56.

[59]The relative vales of the procedures were increased to 200, 225 and 250 units. *Id.* at 2.

Similarly, on January 1, 1976, Maricopa Foundation adopted a revised maximum reimbursement schedule in which the relative values relating to maternity procedures were *all* reduced from those established in February 13, 1974 (although the conversion factors applied to all procedures had been increased).[60] As a result, maximum reimbursement levels for delivery procedures including antepartum care increased an average of only 0.7% annually between February 13, 1974 and January 1, 1976.[61]

It is worthy of note that in 1979 Pima Foundation's maximum reimbursement level for anesthesia services was based upon a conversion factor of $13.00 while its principal underwriter was using a conversion factor of $19.00 on non-Foundation insurance.[62] In his study of maximum reimbursement levels, William J. Lynk concluded that if physicians set that level, it will not exceed the median level of their charges. On the other hand, if insureds participate in setting maximum reimbursement levels, they tend to increase them significantly (to maximize their choice of physicians whose fees will be totally reimbursed).[63]

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[60] *Compare* N.R. 7(c), Ex. MF-120 (procedures 59400-59521) *with* C.R. 7(b), Ex. MF-99.

[61] For the purpose of comparison, it is worth noting that during the relevant period the Arizona consumer price index for "all items" increased an average of 7.2% annually (Hogan & Armstrong, *Consumer Prices: A Record Increase in 1980*, 28 Ariz. Bus. (March 1981) 3 at 5) and the national index for "all items" rose at an average annual rate of 7.7% (United States Bureau of the Census, *Statistical Abstract of the United States: 1980* (1981) at 436).

[62] J.A. 539 ¶ 5.

[63] Lynk at 161–62.

The Undisputed Evidence Shows That Foundation Minimum Standards and Maximum Reimbursement Levels Did Not Inflate Health Care Costs

The facts adduced during the limited discovery controvert Petitioner's unsubstantiated assertion that the "foundations' fee schedules . . . actually have had an inflationary impact which belies their characterization as 'maximum' fee schedules. . . ."[64] From August 1971 through June 1975, the conversion factors of Maricopa Foundation increased at an annual average rate of only 5.2%.[65] During that same period, national medical prices increased an average of 7.5% annually and the national consumer price index increased at an average of 6.9% annually.[66] From 1970 to 1974 the budget for a family of four in the Phoenix metropolitan area, *excluding* medical costs, increased an average of 6.9% annually, while the family's medical costs increased only 5.5% annually.[67]

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[64]Pet. Br. at 7. Petitioner also speculates that the Foundations' 1976 minimum standard setting a $50.00 annual deductible per insured for professional fees, criticized by Arizona as "relatively low", has inflationary effects. Pet. Br. at 6 n.5. This assertion is unsupported by the record and irrelevant to the issues of the case. It suggests Petitioner desires its citizens to pay more medical fees by decreasing their insurance coverage through larger deductibles, a most anomalous argument for a party which purports to represent the interests of the public. In this action Petitioner has only challenged the Foundations' setting of maximum reimbursement levels, not the policy deductibles. Its attacks by innuendo on Foundation practices which it has not seen fit to make issues in this litigation are inappropriate and irrelevant.

[65]These average annual increases ranged from 1.8% for the radiology conversion factor to 6.4% for the anesthesiology classification. *Compare* J.A. 211 ¶ 94 *with* J.A. 212 ¶ 96.

[66]C.R. 68, Ex. A at 434.

[67]*Id.* at 457.

The average annual increase in the maximum allowable reimbursement levels is *less* than the increases in the national and state consumer price indices for "all items".[68] Moreover, the Arizona consumer price index for "medical care" increased at an annual average rate *far below* that of both the Arizona index for "all items" and the national index for "physicians' services", "medical care" or "all items".[69] These relative annual inflation rates refute Petitioner's unsubstantiated claim that the Foundations' maximum reimbursement schedules had an inflationary impact on health care costs.

Since Petitioner itself circulates and promulgates higher maximum reimbursement levels than Respondents, it is hardly in a position to establish that Respondent Foundations' maximum reimbursement levels are inflationary.[70]

SUMMARY OF ARGUMENT

The courts below correctly held on the record before them that Petitioner's motion for partial summary judgment as to Respondents' alleged liability under Sec-

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[68]App. C, Comparisons of Changes in Average Conversion Factors and Consumer Price Indices, at C-1 through C-2.

[69]During the period 1973–1978, the Arizona consumer price index for "medical care" rose an average 1.7% annually while the national index for "physicians' services", "medical care", and for "all items", and the Arizona index for "all items" rose 12.3%, 11.9%, 9.4% and 8.3% respectively. *Id.*

[70]Maricopa Foundation had a contract with Arizona to administer the Comprehensive Medical/Dental Program for Foster Children. It made payments to physicians under that program pursuant to the maximum allowable fee schedule of Arizona's Department of Economic Security, which provided for *higher payments* than those which would have been made under Maricopa Foundation's own maximum levels of reimbursement to doctors providing services to patients insured under Maricopa Foundation endorsed health insurance plans. J.A. 526 ¶ 83. See also the discussion *supra* at 14.

tion 1 of the Sherman Act should be denied. The undisputed facts adduced by Petitioner were insufficient to establish a *per se* price-fixing conspiracy. The maximum reimbursement levels used by Medical Foundations only were shown to limit payments by insurers to Foundation members, decreasing the cost of health insurance. No effect on prices physicians charge patients was demonstrated. Petitioner did not even establish the identity of Respondents' competitors for a relevant market. Moreover, Petitioner itself was shown to engage in the very conduct it seeks to enjoin.

Respondents should have the opportunity to have discovery and prove at trial that the challenged practices are reasonable. They are pro-competitive because they enable Respondents to provide health care consumers with a uniquely desirable product which could not exist unless the Foundations themselves establish the maximum levels of reimbursement to be paid. The result is demonstrable reduction in medical costs. The courts below correctly followed recent decisions of the Court requiring reasoned analysis to determine the appropriate test to apply to challenged conduct, rather than precipitous application of the *per se* rule. *E.g., Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977). The judicial system has not amassed sufficient experience with the health care field to summarily dismiss Respondents' justifications for the challenged arrangements, particularly since the practices of a profession are being scrutinized. *Goldfarb. v. Virginia State Bar*, 421 U.S. 773 (1975); *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).

Furthermore, since Petitioner merely seeks prospective injunctive relief against the challenged practices, this writ presents the Court with a moot question.

Respondents have permanently abandoned the conduct upon which Petitioner relies.

ARGUMENT

I. THE UNDISPUTED FACTS ESTABLISHED ON PETITIONER'S PARTIAL SUMMARY JUDGMENT MOTION DO NOT CONSTITUTE A *PER SE* VIOLATION OF SECTION 1 OF THE SHERMAN ACT

Arizona's petition rests upon a fundamental misapprehension as to the proper result under applicable law because of its sweeping disregard of the facts in this case. Petitioner's Statement in its brief distorts the facts almost beyond recognition. It has attempted to affix conclusory, simplistic and misleading labels to a complex factual setting[71] in an unsuccessful effort to condemn the Respondent Foundations' actions as a *per se* illegal "horizontal maximum price-fixing" combination.[72]

Petitioner has not proven "a compact among competitors on the prices they will receive for their individual services."[73] Petitioner nevertheless urges this Court to hold Respondents' conduct *per se* unlawful, "[b]ecause the applicable inquiry [in cases of this sort] focuses on the nature of the agreement and because the agreement here operates directly upon the prices charged".[74] It seeks to assume away its burden of proof.

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[71]There is substantial dispute among the parties as to many of the facts which Arizona deems material. See J.A. 123, 511.

[72]*E.g.*, Pet. Br. at 25.

[73]*Id.* at 16.

[74]*Id.* at 17.

Respondents have shown *supra* that contrary to Petitioner's claim[75] the Foundations have no control over, and there is no evidence of any effect on, the fees physicians charge patients. No undisputed evidence supports Petitioner's hypothesis that the Foundations have monopoly power over the marketplace.[76] The Foundations do not unilaterally set the prices insurers pay physicians.[77] While Petitioner asserts "a price-fixing conspiracy has been alleged and proven",[78] there is no evidence that the Foundations control the fees charged by either member or non-member physicians.[79] Physicians specifically agree that "participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient."[80]

Respondents do not dispute that an agreed upon fee schedule setting prices charged for professional services would be unlawful *per se*. Unlike the situation in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), where a mandatory minimum fee schedule with respect to the prices to be charged for legal services was found to violate

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[75]See *id.* at 21, where Petitioner states that the Foundations in the present case possess a demonstrated "absolute control over prices".

[76]See note 31, *supra*.

[77]The Foundation minimum standards do not prevent any insurer from bargaining for a fee from an individual member physician which is lower than the Foundation's maximum reimbursement level. Member physicians are free to enter into any agreement they want with insurers or self-insuring health care consumers. Indeed, insurers are also free to pay more than the maximum reimbursement level under a Foundation endorsed plan. J.A. 129 ¶¶ 21–22.

[78]Pet. Br. at 17.

[79]*See, e.g.*, J.A. 31 ¶ 3, 514 ¶ 14.

[80]J.A. 31 ¶ 3, 514 ¶ 14.

Section 1 of the Sherman Act, there is no proof of uniform pricing here. In that case the Court said:

> A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of an actual restraint of trade, would present us with a different question . . . .[81]

Petitioner has failed to carry its burden of establishing undisputed facts showing that Respondents' conduct raised, lowered or stabilized fees charged for medical services. Instead, Petitioner relies entirely on theoretical hypotheses in journal articles, unsupported by any facts.[82]

As in *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics* [1980-2], Trade Cas. (CCH) 63,351 (E.D. Mich. 1980), the maximum reimbursement levels at issue here are not "price fixing", because the health care providers are free to set their fees as they choose and no interference with the pricing mechanism has been shown. Compare *Pharmacist Political Action Committee of Maryland v. Harris,* [1980-81] Trade Cas. (CCH) ¶ 63,886 at 78,593 (D. Md. 1980) (HEW maximum allowable cost "regulations do not force pharmacists to sell at a specified price; they merely limit the amount the government will pay. . .", therefore they are not "price-fixing").

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[81]421 U.S. at 788 n.17.

[82]The Brief for the United States also assumes, without any proof, that the challenged conduct has "the practical effect of minimum price agreements", and that doctors have no financial incentive to charge less than Foundation maximum reimbursement levels. Brief at 8–9. Those assumptions are rebutted by William J. Lynk, who found that when doctors cannot discriminate against insured patients in their fees, the effect is to hold down insurance reimbursement levels. Lynk at 161–62.

As the Court has stated, summary procedures should be used sparingly in antitrust litigation, especially where the district court

> cannot say on [the] record that "it is quite clear what the truth is." It is only when the witnesses are present and subject to cross-examination that their credibility and the weight to be given their testimony can be appraised. Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of "even handed justice."

Poller v. Columbia Broadcasting System, Inc., 368 U.S. 464, 472-73 (1962). As in *Poller*, the District Court "look[ed] at the record on [partial] summary judgment in the light most favorable to . . . the party opposing the motion, and concluded here that it should not have been granted."[83] It correctly found that on the facts currently in the record of this case, precedents holding that price-fixing is illegal do not compel unthinking application of a *per se* rule to Respondents to establish antitrust liability.

Notwithstanding Petitioner's claims, the Court of Appeals in no way required Petitioner to meet a new or unreasonably burdensome standard of proof. It only held that more evidence needed to be in the record before the trial court could determine if the Respondents' conduct should be found to be illegal price-fixing. Numerous decisions of this Court make it clear that not all horizontal agreements allegedly affecting price are *per se* unlawful. "*Per se* rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive."

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[83] 368 U.S. at 473.

Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 50-51 (1977).[84]

Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980), cited extensively by Petitioner, is irrelevant.[85] The *Catalano* case involved the question of characterization of an agreement among wholesalers to fix credit terms in which the Court held "credit terms must be characterized as an inseparable part of the price."[86] The Court ruled that the Ninth Circuit had erred in not making that characterization.

In observing that "It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable."[87] the Court cited *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397–98 (1927); *United States v. Trans-Missouri Freight Association*, 166 U.S. 290, 340–41 (1897); and

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[84]The United States argues that a *per se* rule should be applied because "judicial inquiry into the effect on prices of maximum price agreements would be virtually impossible as a practical matter. . . ." Brief at 17. It is respectfully submitted that federal courts have frequently undertaken much more difficult tasks and brought them to a reasonable resolution. If the United States' argument were taken seriously, a Sherman Act Section 2 case could never be brought to judgment.

[85]Respondents note in passing that Petitioner appears to attempt to impugn the authority of the Ninth Circuit's decision in this action by implying that the reasoning of Judge Sneed should be rejected simply because *Catalano, Inc. v. Target Sales, Inc.*, 605 F.2d 1097 (9th Cir. 1979), *rev'd*, 446 U.S. 643 (1980), a case on which his decision in this action nowhere relied, was overruled. Such reasoning is, of course, spurious and improper. Attempts to inject the *Catalano* decision by claiming that Respondents asserted to the Ninth Circuit that *Catalano* required a Rule of Reason approach (*e.g.*, Brief for the United States at 5) are a strained effort based upon an unjustifiable interpretation of Respondents' briefs to that Court.

[86]446 U.S. at 648.

[87]*Id.* at 649.

United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940). In none of those cases did plaintiff prevail on a motion for summary judgment. In each instance (except the *Trans-Missouri Freight* decision which only remanded the action for further proceedings after the complaint had been dismissed) a determination that the defendant's conduct was unlawful under the Sherman Act took place only after completion of discovery and a trial on the merits. The same is true of *Sugar Institute v. United States*, 297 U.S. 553 (1936), *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), *Federal Trade Commission v. Cement Institute*, 333 U.S. 683 (1948), and the other cases cited by the Court in support of its decision in *Catalano*.

Unlike the situation in *Catalano*, Respondents in this action have argued the pro-competitive justification of offering a cost effective competitive alternative to closed panel prepaid medical plans with Foundation endorsed insurance, something which individual physicians could not separately attempt to do.[88] Respondents further urge as a pro-competitive justification that the effect of the Foundation medical plans is to decrease the cost of medical insurance without any demonstrable effect upon the prices which physicians charge their patients.

Furthermore, the *Catalano* case dealt with acts in a purely commercial industry. In contrast, the challenged conduct in this action concerns pricing in the medical profession. See *Veizaga v. National Board for Respiratory Therapy*, [1977-1] Trade Cas. (CCH) ¶ 61,274 (N.D. Ill.

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[88]Note 8 to the *Catalano* decision made it clear that "Respondents nowhere suggest a pro-competitive justification for a horizontal agreement to fix credit. Their argument is confined to disputing that settled case law establishes that such an agreement is unlawful on its face." *Id.* at 646 n.8.

1977), where the court denied plaintiff's motion for summary judgment, holding that determination of whether the questioned conduct was professional or commercial could not be made before trial. As in *White Motor Co. v. United States*, 372 U.S. 253 (1963), this action should be remanded for further proceedings.

In reality, Petitioner attempts to avoid *any* standard of proof, not merely a burdensome one. It would have the Court make a facile determination that Respondents' conduct is "price-fixing" and thus *per se* illegal, when both the District Court and the Ninth Circuit have found the evidence insufficient at this stage in the proceedings to support that determination.

A. *Since Petitioner Failed to Establish a Horizontal Price-Fixing Conspiracy The District Court Did Not Err in Denying Partial Summary Judgment*

In a carefully reasoned opinion, the District Court concluded "that the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case. Choosing the Rule of Reason approach precludes granting the [Petitioner's] motion for partial summary judgment on the issue of liability because there is insufficient evidence as to the purpose and effect of the allegedly unlawful practices and the power of the [Respondents]."[89] Petitioner has failed to demonstrate that the District Court erred in choosing to apply the Rule of Reason test to analyze Respondents' conduct. Instead it attacks the language of Judge Sneed's opinion affirming that determination as if Judge Sneed were the respondent on this writ.

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[89]Pet. App. D at 47.

In affirming the District Court's ruling, the Ninth Circuit simply allowed Respondents an opportunity to show the reasonableness of their conduct at trial. That is perfectly consistent with the case law and does not establish any new "reasonableness of the price" defense as Petitioner contends. A careful reading in their entirety of the majority opinions affirming the denial of summary judgment inevitably leads to the conclusion that at this early stage in the proceedings insufficient undisputed evidence has been introduced by Petitioner to convince either the District Court or the Circuit Court that the conduct at issue should simply be called "price-fixing".

The courts' determinations are amply supported by numerous decisions of the Court which make it clear that not all horizontal agreements affecting price are unlawful on their face. In *Broadcast Music, Inc. v. Columbia Broadcasting Systems, Inc.*, 441 U.S. 1 (1979), the Court rejected the simplistic *per se* approach to antitrust analysis favored by Petitioner. Holding that the Rule of Reason should govern the determination of the legality of the blanket licensing practice at issue (which had been held to be *per se* illegal price-fixing by the Court of Appeals), the Court observed that while the *per se* rule "is a valid and useful tool of antitrust policy and enforcement", courts must not be too quick to seize upon it as a replacement for reasoned analysis of challenged practices: "[E]asy labels do not always supply ready answers."[90]

Petitioner's rush to affix the label of horizontal price-fixing to the Foundations' practices stands at odds with the searching analysis mandated by *Broadcast Music*:

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[90] 441 U.S. at 8.

> To the Court of Appeals and CBS, the blanket license involves "price fixing" in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license it sells. But this is not a question simply of determining whether two or more potential competitors have literally "fixed" a "price". As generally used in the antitrust field, "price fixing" is a shorthand way of describing certain categories of business behavior to which the *per se* rule had been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is "plainly anticompetitive" and very likely without "redeeming virtue." Literalness is overly simplistic and often overbroad. . . .
>
> Consequently, [citation omitted] "[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations. . . ."[91]

The Court concluded that "[n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints."[92]

Broadcast Music is the most recent in a line of cases including *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), in which the Court, overruling its earlier decision in *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365 (1967), condemned the precipitous application of the *per se* rule when not appropriate to a particular antitrust case. The Court noted that *Schwinn* itself "was an abrupt and largely unexplained departure from *White Motor Co. v. United States*, 372 U.S. 253, 83

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[91] *Id.* at 8–9.

[92] *Id.* at 23.

S. Ct. 696, 9 L. Ed. 2d 738 (1963), where only four years earlier the Court had refused to endorse a *per se* rule for vertical restrictions."[93]

In rejecting the truncated *per se* analysis employed in *Schwinn*, the Court plainly insisted that courts focus on the substantive orientation of the antitrust laws in analyzing particular cases, declaring: "Realities must dominate judgment. . . . The Anti-Trust Act aims at substance."[94] The Court emphasized that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anti-competitive"[95] and warned: "[W]e . . . make clear that departure from the rule of reason standard must be based upon demonstrable economic effect rather than—as in *Schwinn*— upon formalistic line drawing."[96] Petitioner asks the Court to disregard that admonition by applying conclusory labels to the Foundations' activities and blindly applying the *per se* rule with no showing of "demonstrable economic effect".

There is no showing by Petitioner of any causal link between Respondents' challenged conduct and the fees charged by doctors. The journals cited by Petitioner contain theoretical arguments made in a vacuum, without any attempt at empirical verification. On the other hand, William J. Lynk's recent study which reviewed empirical data establishes that when physicians set maximum reimbursement levels for health insurance plans, the levels are likely to be *lower* than if the levels are set

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[93]*Continental T.V.*, 433 U.S. at 47.

[94]*Id.*, quoting *Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 360 (1933).

[95]433 U.S. at 49–50.

[96]*Id.* at 58–59.

by others: "The principal empirical finding is that greater physician representation on plan boards generates reductions in both the maximum and average levels of reimbursement."[97] Respondents should be given an opportunity to demonstrate at trial that their conduct in the particular factual circumstances of this case has the salutory effect predicted by Lynk's theory and the general empirical evidence.

As the Court noted in *White Motor Co. v. United States*, 372 U.S. 253, 263 (1963), (and reiterated, in substance, in *Broadcast Music*),[98] "We need to know more than we do about the actual impact of these arrangements on competition to decide whether they have a 'pernicious effect on competition and lack . . . any redeeming virtue' [citation omitted] and therefore should be classified as *per se* violations of the Sherman Act". Here there has been too little antitrust experience with the Medical Foundation concept of offering a lower cost alternative health insurance plan to blindly apply, as Petitioner would, a rigid *per se* analysis in the present case. The District Court was correct in refusing to do so.

The antitrust laws were not intended to straitjacket imaginative experimentation in fields such as the professions not traditionally subject to antitrust scrutiny. In *Goldfarb*, the Court went out of its way to state

> The fact that a restraint operates upon a profession as distinguished from a business is,

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[97]Lynk at 160. Reliance by the authors cited by Petitioner on Kass & Paulter, Federal Trade Commission Report on Physician Control of Blue Shield Plans (1979), makes their findings suspect. Lynk shows that the F.T.C. study used dummy variables based on assumptions which prove unsupported by the empirical data. The F.T.C. results are statistically unsound. See Lynk at 171–72 n.19.

[98]441 U.S. at 10 & 16.

> of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one which we are confronted today.[99]

In *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), the Court reiterated that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context."[100] The Court then quoted in its entirety note 17 from the *Goldfarb* decision in the text of the *Professional Engineers* decision.

The District Court's decision to apply the Rule of Reason in this case was further mandated by the Ninth Circuit's decision in *Boddicker v. Arizona State Dental Association*, 549 F.2d 626 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977).

> [T]he Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise.
>
> As we interpret the Court, to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in

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[99]421 U.S. at 788 n.17.

[100]435 U.S. at 686.

> tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve.
>
> We recognize this interpretation provides only the principle to be employed in deciding specific cases. It is not a blueprint which will resolve all controversies and by which the professions can check their structures to determine whether they comply with the Sherman Act. Any such blueprint must await additional guidance by the Supreme Court and resolution of specific cases by this and other courts.[101]

The Ninth Circuit correctly stated the rule in *Boddicker* and correctly applied the rule to Petitioner's partial summary judgment motion.

Contrary to Petitioner's assertion, Judges Sneed and Kennedy agreed that the further evidence which would be adduced at trial might convince the trial court to classify the Respondents' challenged conduct as "price-fixing" which in future cases could be subject to a *per se* standard of liability. They simply found a *per se* analysis inappropriate at the summary judgment stage of these proceedings, noting that the professions had only recently been brought within Section 1 of the Sherman Act[102] and that guidelines for professional conduct are still being written.

As Judge Kennedy stated, "[p]er se rules should be derived from considerations of economic impact in par-

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[101] 549 F.2d at 632.

[102] 643 F.2d at 556; citing *Goldfarb*, 421 U.S. at 785–88.

ticular cases illustrating the category of prohibited acts and therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules."[103]

B. *Medical Foundation Endorsed Insurance Plans Are a Unique Product Which Cannot Exist Unless Maximum Reimbursement Levels for the Insurance Are Established by Medical Foundations*

The Foundation endorsed insurance plans are, it is respectfully submitted, subject to the same type of analysis as the blanket licenses in the *Broadcast Music* case. As in that case, Petitioner has failed in this action to establish any agreement by competitors concerning prices they will sell at on an individual basis. A Foundation endorsed insurance plan is a health care service different from that which any individual physician or individual insurer could separately provide the public.

As in *Broadcast Music*, as a practical matter it is impossible for an individual insurer to negotiate with a large proportion of the physicians in a community to establish uniform standards for medical care and uniform defined dollar limits for maximum reimbursement levels which would bind the treating physician.[104] Foundation endorsed insurance is unique in guaranteeing to the insureds 100% payment of physicians' bills (after the payment of a deductible) for treatment from a large number of physicians in private practice in the community, and in providing this service through a number of insurers at competitive insurance premiums. It is something no individual doctor or insurer could do.[105]

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[103]643 F.2d at 560.

[104]Compare 441 U.S. at 5.

[105]Compare *id.* at 23.

Respondents have urged and are prepared to prove at trial that, as in *Broadcast Music,* Foundation endorsed health insurance results in substantial lowering of costs and, by providing insureds with a large number of participating physicians throughout the community, produces a "whole [which] is truly greater than the sum of its parts. . . ."[106] The empirical evidence suggests that physician control over reimbursement levels reduces those levels and increases physician willingness to accept lower levels of reimbursement as payment in full.[107] Petitioner concedes that, as in *Broadcast Music,* the "marketable package" of Foundation endorsed insurance is clearly preferred by many consumers.[108] The Court should not foreclose Respondents from proving that Foundation endorsed insurance is a type of conduct which should be praised and encouraged instead of being condemned in a knee-jerk reaction to "price-fixing".

In *Broadcast Music* the Court reiterated that the *per se* rule is not employed until after considerable experience with the type of challenged restraint.[109] When it is urged that Respondents must establish that their conduct is necessary[110] in order for them to prevail, it would be unfair to rule in Petitioner's favor on a motion for partial summary judgment made before Respondents are given an opportunity to conduct any meaningful discovery.

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[106]*Id.* at 21–22.

[107]Lynk at 170–71.

[108]See Pet. Br. at 5 n.4, discussed at note 31, *supra.*

[109]441 U.S. at 19 n.33.

[110]See, *e.g.*, Brief for the United States at 23.

II. THE WRIT IS MOOT BECAUSE PETITIONER RELIES UPON ALLEGED CONDUCT WHICH DOES NOT AND WILL NOT OCCUR

Among the factual allegations relied upon by Petitioner in its Brief are (i) membership voting on adoption of "fee schedules"[111] (ii) use of relative values and conversion factors as the components of a "fee schedule"[112] and (iii) Maricopa County Medical Society's appointment of Maricopa Foundation's governing Board of Trustees.[113]

As set forth above at page 10, as a result of changes in the by-laws of Maricopa Foundation, the Maricopa County Medical Society does not appoint the Foundation's governing board and Foundation members do not vote on maximum reimbursement levels. Also, the Foundations have moved away from use of relative values and conversion factors to determine their maximum reimbursement levels.

In view of the significant changes in the factual situation since Arizona brought this action in 1978, it would be inappropriate to find a violation of the Sherman Act and enter an injunction, as Petitioner requests, without further consideration of the case by the trial court in light of the intervening changes. *Fusari v. Steinberg*, 419 U.S. 379, 390 (1975) (remanding action in which District Court had entered an injunction "for reconsideration in light of the intervening changes in Connecticut law"). "The purpose of an injunction is to prevent future violations, *Swift & Co. v. United States*, 276 U.S. 311, 326 (1928), and, of couse, it can be utilized even without a

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[111]Pet. Br. at 4.

[112]*Id.*

[113]*Id.* at 2 n.1.

showing of past wrongs. But the moving party must satisfy the court that relief is needed. The necessary determination is that there exists some cognizable danger recurrent violation, something more than the mere possibility which serves to keep the case alive." *United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953) (affirming dismissal of suit to enjoin violations of § 8 of the Clayton Act).

Since Petitioner does not seek any damages for alleged past violations, this case is moot unless it establishes a reasonable expectation that the allegedly wrongful behavior is likely to recur. *S.E.C. v. Medical Committee for Human Rights*, 404 U.S. 403, 406 (1972) This writ is from denial of partial summary judgment on a sparse record and the action simply should be remanded to the District Court for further proceedings to develop the current state of affairs and whether Petitioner has any right to relief under them. That is properly a matter for the trial court. *United States v. Concentrated Phosphate Export Association, Inc.*, 393 U.S. 199, 203-04 (1968).

III. NOT ALL HORIZONTAL MAXIMUM PRICE-FIXING IS A *PER SE* VIOLATION OF SECTION 1 OF THE SHERMAN ACT

Petitioner relies upon *Kiefer-Stewart Co. v. Joseph E. Seagram Co.*, 340 U.S. 211 (1951), *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), and *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), to assert that all agreements among competitors with respect to maximum prices are *per se* unlawful. Respondents respectfully urge that there is no inconsistency between the denial of partial summary judgment in this action and the opinions cited by Petitioner.

In *Kiefer-Stewart*, the Court reinstated a jury verdict that unlawful maximum resale price-fixing had oc-

curred, citing only *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). Without any further discussion it stated, "[S]uch agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in acccordance with their own judgments."[114] However, as the Court later noted in *Albrecht v. Herald Co.*,[115] the maximum prices that were the object of the decision in *Kiefer-Stewart* were also minimum prices set under the fair trade laws of that time.[116]

While the Court stated in *Albrecht* its determination to "adhere to" the *Kiefer-Stewart* decision,[117] that determination was based in part upon the defendant's use of exclusive territories which were determined to be unlawful under *United States v. Arnold Schwinn & Co.*, 388 U.S. 365, 373 (1967).[118] Since the Court subsequently overruled the *Schwinn* case in *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), the rationale of *Albrecht* is therefore suspect.

The only other explanation which the Court gave for its determination that the maximum price fixing was illegal in *Albrecht* was that

> [m]aximum and minimum price fixing may have different consequences in many situations. But schemes to fix maximum prices, by substituting the perhaps erroneous judgment of a seller for the forces of the competitive market, may severely intrude upon the ability of buyers

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[114]340 U.S. at 213.

[115]390 U.S. at 153 n.9.

[116]See *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 182 F.2d 228, 230–31 (7th Cir. 1950), *rev'd*, 340 U.S. 211 (1951).

[117]390 U.S. at 152.

[118]*Id.* at 154; see also, *id.* at 150 n.6.

> to compete and survive in that market. . . . Maximum price fixing may channel distribution through a few large or specifically advantaged dealers who otherwise would be subject to significant nonprice competition. Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasingly likely as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all of the attributes of an arrangement fixing minimum prices.[119]

The latter part of the Court's rationale in *Albrecht* has no application here, since this case does not involve either resale by a dealer of goods sold by the party fixing the price nor a situation in which the maximum price is nearly always the price charged. Indeed, Petitioner complains loudly that 85 to 95 percent of the members of the Foundations charge more than the Foundations' maximum reimbursement levels.[120]

The other argument advanced in the *Albrecht* opinion is an unfortunate confusion between protecting competition and protecting competitors. The Court subsequently reaffirmed that the Sherman Act protects "competition, not *competitors*. . . ." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977); quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 320 (1962).

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[119]*Id.* at 152-53.

[120]Pet. Br. at 7. This high percentage of charges above the Foundation maximum reimbursement levels demonstrates that the Foundations work. In his study, William J. Lynk found that a typical Blue Shield's maximum reimbursement level is 15 to 20 percent above the median charge so that most doctors are paid in full by the insurers. Lynk at 162n.9. A Foundation endorsed insurer would not pay most fees in full.

Mr. Justice Douglas in his concurring opinion pointed out that *Albrecht* should be treated as a Rule of Reason case because it was factually close to *White Motor Co. v. United States*, 372 U.S. 253 (1963). As in *White Motor Co.* (which regained its vitality in the light of the Court's determination in *Continental T.V.* to overrule *Schwinn*), this action should be remanded for findings on the actual impact of the arrangements on competition. As Mr. Justice Harlan recognized in his dissent in *Albrecht*:

> When price floors and price ceilings are placed side by side, then, and the questions asked of each, "Does analysis justify a no-trial rule?" The answers must be quite different. Both practices share the negative attribute that they restrict individual discretion in the pricing area, but only the former imposes upon the public the much more significant evil of lessened competition, and, as just seen, the latter has an important arguable justification that the former does not possess [preventing resellers from reaping monopoly or supercompetitive profits]. As the Court's opinion partially but inexplicitly recognizes, in a maximum price case the asserted justification must be met on its merits, and not by incantation of a *per se* rule developed for an altogether different situation.[121]

Respondents' acts do not have any effect on prices charged by physicians to their patients. They only affect prices paid by insurers for services rendered to insureds covered by Foundation endorsed plans to the extent a Foundation member provider charges the patient more than the maximum reimbursement level. By limiting the insurers' costs, the maximum reimbursement levels tend to have a favorable effect upon the cost of premiums for

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[121] 390 U.S. at 159.

Foundation endorsed health insurance.[122] But since the Foundation endorsed insurance plans do not permit member providers to seek payment of the excess over that reimbursement level from the insured patient and do not permit physicians to discriminate in billing Foundation insured patients as compared to non-Foundation insured patients, the Foundation maximum reimbursement levels do not affect what any patient pays to physicians for medical services.[123]

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), Blue Shield was accused of fixing the maximum prices for prescription drugs. Although the Court had the opportunity to examine the alleged maximum price-fixing of prescription drugs by Blue Shield, it declined the opportunity to do so.[124] In determining that Blue Shield was not exempt from the Sherman Act by Section 2(b) of the McCarran-Ferguson Act, the Court noted that, "The United States in its *amicus* brief urging affirmance has taken the position

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[122]The United States pointed out in its *amicus* brief in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), that maximum price-fixing "serves to help the policyholders find low-overhead pharmacies with which to deal. Moreover, it provides pharmacies with incentives to reduce their distribution costs in order to be able to take advantage of [the maximum price] and still make a profit. . . . Nothing in the antitrust laws requires drug purchasers (or Blue Shield acting as their purchasing agent) to offer the greater compensation necessary to satisfy less efficient pharmacies or suppliers interested in providing expensive but unwanted services at the point of sale. To the contrary, antitrust policy seeks to preserve to consumers the opportunity to obtain a better deal." Brief for the United States as *amicus curiae* at 11–12. Surprisingly the United States has taken an entirely different position in its *amicus* brief in this matter.

[123]Since physicians may want to charge less to attract additional non-Foundation patients, they have an incentive to charge less than the maximum reimbursement level to all patients.

[124]Compare *United States v. Utah Pharmaceutical Association*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962).

that the Pharmacy Agreements probably do not violate the antitrust laws, though recognizing that the issue is not presented here."[125]

To evade its argument's factual difficulty, Petitioner theorizes that the *likely* effect of the challenged conduct is an increase in what physicians bill. This hypothesis is buttressed by reference to articles written by certain theorists who have not verified their belief through empirical data. As Respondents have shown above, when empirical data is reviewed the results refute Petitioner's theory.

The cases upon which Petitioner relies deal with resale price maintenance in the context of agreements between suppliers and distributors. Whatever the merit of Petitioner's arguments in the resale price maintenance context, they are not valid in the context of agreements among suppliers entered for the limited purpose of establishing maximum insurance reimbursement levels for a separate service offered by them as a group. Compare *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979).

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[125]440 U.S. at 210n.5.

CONCLUSION

The determination of the Court of Appeals to affirm denial of partial summary judgment by the District Court should be affirmed and the case remanded to the District Court for further proceedings.

Respectfully submitted,

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APPENDICES

APPENDIX A

BY-LAWS

OF THE

MARICOPA FOUNDATION FOR MEDICAL CARE

REVISED AS OF JANUARY 25, 1980*

CHAPTER I

GENERAL PROVISIONS AND PROPERTY INTERESTS

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CHAPTER II

MEMBERSHIP

Section 1. Classes of membership:

There shall be the following classes of membership in this corporation: Participating, Cooperating and Health Care Institution Participating Members. These classifications shall not be mutually exclusive.

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*Only those revisions which altered the Maricopa Foundation By-Laws as revised August 14, 1972 (C.R. 7(b), Ex. MF-122) are reproduced *infra*. Identical provisions are indicated by "* * *".

Section 2. Qualifications of participating members:

* * *

Section 3. Rights and privileges of participating members:

Participating members shall have the privilege of holding any office in the corporation, and the privilege of membership on any committee of the corporation.

Section 4. Qualification of cooperating members:

* * *

Section 5. Rights and privileges of cooperating members:

The rights and privileges of Cooperating Members, including terms of membership shall be exactly the same as specified in Section 3 and 6 of this chapter with respect to Participating Members. Procedure for admission of Cooperating Members shall be exactly the same as provided in Section 7 of this chapter for admission of Participating Members. Cooperating Membership shall be non-transferrable and subject to the provisions of Section 8 of this chapter.

Section 6. Term of membership:

* * *

Section 7. Procedure for admission to participating membership:

Any person who desires to become a participating member of this corporation shall fill out and sign in duplicate the application blank provided for that purpose by the corporation. Such application blank shall be in the form or forms determined by the Board of Trustees, and shall contain a clause stating in substance that the applicant agrees to be bound by the constitution, by-laws, and rules and regulations of this corporation; that the applicant, as long as his membership in this corporation

is effective, agrees to be bound by any and all rules, regulations, reimbursement schedules, and the like, adopted by this corporation; and that the applicant realizes and understands that if he is elected to membership, his membership shall be for a period of only one year, or less, as the case may be and that if he fails to re-apply for membership in accordance with the constitution, by-laws and rules and regulations of this corporation, his membership shall automatically terminate on its expiration date.

Said application shall be filed with the secretary-treasurer at the principal office of the corporation. The application shall be referred by the secretary-treasurer to the membership committee, which shall investigate the background and present status of the applicant, and shall report to the Board of Trustees, with a recommendation thereon. At the next meeting of the Board of Trustees, the president shall announce the names of those applicants submitted to it by the membership committee, and the committee recommendation, if any. Each applicant shall thereupon be voted on individually; and it shall require a two-thirds majority vote of the Board of Trustees to elect to membership.

Not more than ninety (90) days, nor less than thirty (30) days prior to the uniform membership termination date, each participating member of this corporation who desires to become a participating member of the corporation for another year shall file an application therefor in duplicate with the secretary-treasurer at the principal office of this corporation. It shall be the duty of the secretary-treasurer to send application forms to each participating member of this corporation at least ninety (90) days prior to the expiration of his term of membership. The procedure for subsequent admissions' to participating membership in this corporation shall be the same and shall require the same vote as for initial admission to membership in this corporation.

At any time, any person qualified to apply for participating membership as specified in these by-laws may apply therefor in the manner outlined in this Chapter II; and if he is elected to membership, said membership shall terminate on the uniform membership termination date and applications for new membership must be made in accordance herewith.

Section 8. Non-transferability of membership:

* * *

Section 9. Membership roll:

* * *

Section 10. Health Care Institution Participating Membership:

* * *

CHAPTER III

MEETINGS OF MEMBERS

Section 1. Annual meetings:

Annual meetings of paricipating members shall be held on the third Monday in January each year. Notice of all annual meetings of members is hereby dispensed with.

Section 2. Regular meetings:

Regular meetings of the participating members shall be held at the time and place as determined by the Board of Trustees. Notice of all regular meetings of members is hereby dispensed with.

Section 3. Special meetings:

Special meetings of participating members, for any purpose or purposes whatsoever, may be called at any time by the president or the Board of Trustees; or by one-third of the members in that class. Notice of special meetings shall be given to each member entitled to vote thereat either personally or by mail addressed to such member at his address appearing upon the books of the corporation, at least ten (10) days in advance of the date of such special meetings; and such writen [sic] notice shall also state the place, day and hour of such meeting and the general nature of the business to be transacted. No business shall be transacted at a special meeting other than stated in the purposes set forth in the notice. Special meetings may be held at the principal office of the corporation, or at any other place within the County of Maricopa.

Section 4. Adjourned meetings, and notice thereof:

* * *

Section 5. Entry of notice:

* * *

Section 6. Consent of absentees:

* * *

Section 7. Action without meeting:

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CHAPTER IV

CORPORATE POWERS

Section 1. Corporate powers vested in Board of Trustees:

* * *

Section 2. Powers of Trustees:

Subject to these by-laws, the Board of Trustees shall have full and sole power to control and manage the property and conduct the affairs and business of this corporation; and in furtherance of the foregoing powers, but not in limitation thereof, it shall have power:

First: * * *
Second: * * *
Third: * * *
Fourth: * * *
Fifth: * * *
Sixth: * * *
Seventh: To consider, approve or disapprove all recommendations of any committees; and to adopt reimbursement schedules for medical services, which when adopted by a majority vote of the Board of Trustees shall be binding upon all participating and cooperating members, of this corporation while, and so long as, they are participating and cooperating members in good standing of this corporation.

CHAPTER V

BOARD OF TRUSTEES

Section 1. Terms of office:

The first trustees designated as such in the Articles of Incorporation of this corporation shall hold office

and exercise all powers granted to the Board of Trustees until the next regular annual meeting of this corporation. Thereafter, a new Board of Trustees shall be elected in accordance with these by-laws. The new Board of Trustees so elected may be composed of all, some, or none of the first trustees designated as such in the Articles of Incorporation. Four (4) members of said Board of Trustees shall be elected for a period of three (3) years, four (4) for a period of two (2) years, and four (4) for a period of one (1) year. Yearly thereafter four (4) new members shall be elected to the Board of Trustees of this corporation for a period of three (3) years.

Section 2. Removal from office:

* * *

Section 3. Vacancies:

* * *

Section 4. Composition of Board of Trustees:

* * *

CHAPTER VI

MEETINGS

Section 1. Regular meetings:

Regular meetings of the Board of Trustees shall be held without call on the third Monday of each and every month. Notice of all such regular meetings of the Board of Trustees is hereby dispensed with.

Section 2. Special meetings:

* * *

Section 3. Written consents and waivers of notice:

* * *

CHAPTER VII

OFFICERS

* * *

CHAPTER VIII

DUTIES OF OFFICERS

* * *

CHAPTER IX

EXECUTIVE COMMITTEE AND OTHER COMMITTEES ESTABLISHED BY TRUSTEES

Section 1. Executive Committee:

* * *

Section 2. Standing Committees:

Standing committees of this corporation shall be as follows:

a. Constitution and by-laws committee.
b. Membership committee.
c. Minimum standards committee.
d. Peer review committee.

Section 3. Qualifications and terms of office of committee members:

* * *

Section 4. Composition and duties of committees:

* * *

Section 5. Other committees:

* * *

CHAPTER X

ELECTIONS

Section 1. Board of Trustees:

First: The Board of Trustees shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.

Second: The annual election of Trustees shall be held on the last day of November of each year.

Third: There shall be no ballot other than the official ballot as provided by the secretary. On each ballot, shall be printed, in alphabetical order, the names of the nominees for each office. After the name of each nominee shall be placed a line on which the voter shall make a mark to indicate the nominee for whom he chooses to vote.

Fourth: The secretary shall mail one official ballot with instructions to each qualified participating member of the Foundation within ten days after the October meeting of the Board of Trustees. A member ber voting must write his name on the official outside envelope which shall contain his ballot sealed in the official inside envelope. The official outside envelope shall remain sealed until the voter's

name has been checked off the list of qualified participating member voters by the secretary and when opened, the sealed inside envelope containing the ballot shall remain sealed and so be deposited in the official ballot box. Such ballot must be delivered, personally or by mail, at the polls before the hour of 5:00 p.m. on the day of the election. After the closing of the polls, the inside envelope shall be opened and the ballot shall be counted by the Board or a group of tellers authorized by the Board, provided, however, that at least one member of the Board of Trustees shall be present at the counting of the votes.

Fifth: The majority of the votes case on any ballot shall be necessary to elect. If more than two nominees appear on the ballot and no nominee receives the majority of the votes cast on the first ballot, all of the nominees except the two highest shall be dropped and a second mailed ballot shall be taken in the same manner as the first.

Sixth: In case the only two nominees for the office receive an equal number of votes, election shall be determined by lot in such manner as the Board of Trustees may prescribe and the person whose favor it shall result shall be declared duly elected.

Section 2. Officers:

* * *

Section 3. Nominating Committee:

First: The Nominating Committee of the Foundation shall be the members of the Executive Committee. The Nominating Committee shall choose its nominees by a majority vote of its members and shall report its nominations to the Board of Trustees at the September Board meeting of each year.

Second: These nominations shall be published to the participating members of the Foundation by the end of September of each year and additional nominations for the Board may be made from the membership prior to the October Board meeting of the Board of Trustees.

CHAPTER XI

MISCELLANEOUS

Section 1. Inspection of corporate records:

* * *

Section 2. Checks, drafts, etc.:

* * *

Section 3. Annual report:

* * *

Section 4. Contracts, etc. — how executed:

* * *

Section 5. Inspection of by-laws:

* * *

Section 6. Rules of order:

* * *

Section 7. Rules of Professional conduct:

Such principles of professional conduct as this corporation may adopt by a majority vote of its members, shall govern this corporation and all members thereof.

Section 8. Disciplinary action:

A member who is guilty of a criminal offense or gross misconduct, either as a physician or as a citizen, or violates any of the provisions of the Articles of Incorporation of this corporation or these by-laws, or any principles of professional conduct adopted by this corporation, or who acts contrary to or in violation of any contracts, agreements, or statements of principle of this corporation, shall be liable to censure, suspension or expulsion. The procedure to be followed by this corporation with respect to censure, suspension, or expulsion of a member shall be the procedure now or hereafter contained or provided in the by-laws of the Maricopa County Medical Society as now existing or as they may be hereafter amended; and said procedure is hereby incorporated into these by-laws by this reference; provided, however, that this corporation may, but shall not be required to, appoint a judicial council to hear disciplinary matters, if it so desires. Such judicial council, if appointed, shall be appointed by a majority vote of the Board of Trustees.

Section 9. Fiscal and Administrative Year:

* * *

CHAPTER XII

AMENDMENTS

* * *

APPENDIX B

MARICOPA FOUNDATION FOR MEDICAL CARE

STANDARDS FOR FOUNDATION-ENDORSED GROUP INSURANCE PROGRAMS

AS AMENDED

APRIL 1, 1980

* * *

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STANDARDS FOR ENDORSEMENTS GROUP INSURANCE PROGRAMS

I. GENERAL AND ADMINISTRATIVE

1. These Standards shall apply to all groups written with an effective date or renewal date on or after April 1, 1980. Unless otherwise stated, it is the intention of these Standards to cover expenses of accidents, illness or suspected illness. *Nothing in these standards shall be construed so as to prevent the insurance contract from conforming with the applicable state law.*

2. The schedule of benefits shall be in accordance with the enclosed maximum reimbursement schedule adopted by the Maricopa Foundation on April 1, 1980. Benefit payments for all professional services will be based on the lesser of the physician's usual fee or the maximum reimbursement schedule.

3. Contracts may be written covering the subscriber alone providing the contracts meet the Standards. If dependents are covered they may have less benefits than the subscriber, provided the dependent benefits at least meet the Standards. Dependent definition for Foundation-endorsed plans shall be: Insured spouse and unmarried children less than 19 years of age; or the insured's unmarried children under 23 years of age who attend an accredited educational institution on a full-time day basis and depend upon the insured for support and maintenance. Persons insured as employees under the same policy are not included as dependents.

Unmarried children 19 years or older who are prevented from pursuing normal activities due to mental retardation or physical handicap and who are wholly dependent on the insured for support and maintenance are also eligible for coverage. However, any individual eligible to be insured under a policy as a dependent shall

not be considered a dependent if in full-time military, naval or air service.

4. Claims review by the Foundation for Medical Care:

This is defined as meaning that the Foundation must receive all claims for review. These claims will be processed by the Foundation and drafts executed under draft authority from the various underwriters.

The Foundation shall be paid a percentage of the group's accident and health premium for physician peer review of claims, processing claims and executing drafts. For this service the Foundation is to receive 4% of the premium per contract year. This fee should be paid to the Foundation on a monthly basis as the premium is received from the group. The percentage of premium applies whether or not the Foundation has draft authority.

If it is the desire of the underwriter that the Foundation office be responsible for certification of eligibility then an additional fee of 1/2 of 1% of the annual premium may be charged by the Foundation.

Claim forms and other forms used by the underwriter shall meet with Foundation approval. *The American Medical Association's uniform claim form is preferred.*

During the contract year, if the Foundation is not allowed to keep the original claim file for a reasonable time, the underwriter must reimburse the Foundation for the cost of duplication of the file.

5. Professional payments to be restricted to duly licensed:

a. Physicians and Surgeons
(Doctors of Medicine)
b. Doctors of Dentistry.

c. Physicians and Surgeons
(Doctors of Osteopathy)
d. Doctors of Podiatry
(Podiatrists)

(Unless otherwise provided by law)

6. No program shall be deemed to meet Foundation specifications unless the proposal is accompanied by a letter of approval from the Foundation for Medical Care or a letter from the Insurance Company or Service Plan stating the plan meets the Foundation standards. If granted, such approval shall be for a period of one year and a copy of the proposal shall be filed with the Foundation for Medical Care. If an insurance company wishes to file with the Foundation a letter stating that all specifications do, in fact, meet Foundation standards such a blanket letter will take the place of individual approval of each and every proposal.

7. Annual review of the program for Foundation approval must be secured prior to the renewal date of the contract. Any proposed rate changes shall be made known to the Foundation at the time the underwriter seeks said annual approval. The insuror will automatically give the Foundation at the start of each policy year the number of employees covered, and an estimate of the expected annual premium income, and will provide copies of the periodic experience reports normally provided to the brokers, agent and/or group.

8. If the Standards for Foundation endorsement are met and the Foundation endorses the program, participating members of the Foundation thereby agree with the following:

To accept as payment in full, payments in accordance with the schedule adopted by the Foundation's Board of Trustees.

If the physician is a member of the Foundation for Medical Care, assignment of benefits

will be automatic and payment made directly to the physician. Notification of payment will also be sent to the insured.

EXCEPTION to the above agreement shall be as follows:

A participating member of the Foundation shall have the right and privilege of collecting from the patient up to his or her usual fee if the patient refuses to assign benefits of the program to the participating member. If the patient or his family has multiple coverage (by multiple coverage it is meant other insurance policies which will indemnify the insured for professional services regardless of payment made by Foundation endorsed programs), a participating member of the Foundation has the right and privilege to collect from the patient up to but not exceeding his or her usual fee.

It is the responsibility of the patient to make known at the initial visit the existence of other *possible* additional insurance benefits which may provide coverage. The total combined payment will in no instance exceed the amount charged for the service.

9. The Foundation for Medical Care in endorsing any program expects full cooperation by patients in the payment of co-insurance and deductibles of the contract and payment for the items which are not covered.

10. The Foundation for Medical Care will furnish a list of participating physicians to any member of a Foundation-endorsed health insurance plan. It is the responsibility of the patient, however, to ascertain in each instance whether or not a doctor is a participating member of the Foundation.

11. The Foundation shall not be responsible for delay in the performance of any agreement, nor for nonperformance of any agreement which is caused by, in whole or part, the failure of either the underwriting In-

surance Company, the employer, or the patient to furnish any required information promptly. If it should be necessary for the Foundation to repeat any services because of incorrect or incomplete data furnished by the underwriting company, the employer or the patient, an additional fee for such service may be charged. Foundation shall be entitled to rely on the information so provided as to accuracy and completeness and shall have no duty or responsibility to verify such information once supplied by the underwriting Insurance Company or the employer.

II. *STANDARDS FOR BASIC GROUP INSURANCE PROGRAMS MEDICAL COVERAGE — REQUIRED*

* * *

III. *STANDARDS FOR MAJOR MEDICAL GROUP INSURANCE PROGRAMS (i.e., SUPPLEMENTAL MAJOR MEDICAL OR TO BE USED WITH BASE PLANS AS A SUPER-IMPOSED MAJOR MEDICAL)*

* * *

IV. *STANDARDS FOR COMPREHENSIVE MAJOR MEDICAL INSURANCE PROGRAMS*

(Coverage may not be inconsistent with required Basic Plan minimums.)

* * *

V. *MODIFICATIONS*

1. Any deviations from the Foundation Standards for any group must be approved in writing by the Board of Trustees of the Maricopa Foundation for Medical Care.

VI. *RECOMMENDED ADDITIONAL COVERAGE — NOT REQUIRED*

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MEDICINE

GENERAL INFORMATION AND INSTRUCTION

1. The following visits, examinations, consultations and similar services are the most frequently recurring and widely variable items of medical care. The time requirements of these services range from the briefest possible contact with the patient to the time-consuming interview and exhaustive examination needed to appraise a complex medical problem.

The following gradation of services is listed in an attempt to reflect the relative values of the various times and skills required. These services may be employed for care of illness or health supervision.

Health supervision does not involve as a primary purpose the diagnosis and treatment of illness. Its purposes include an appraisal of the individuality and developmental level of the patient and the promotion of optimal health and personality growth as well as the prevention of illness. These services are included in items 9000 through 9030 in accordance with time and complexity of the services rendered. (See 9050, *et seq.*, for psychiatric services.)

2. "Sv." Items: "Sv." in the value column indicates the value is to be calculated as the sum of the various services rendered, (e.g., office, home, nursing home or hospital visit, consultation or detention, etc.) according to the ground rules covering those services.

3. Medical care of an unusual or unlisted value may occur which represents a type of service over and beyond listed procedures. If substantiated "By Report" (See Rule 5), additional unit values may be warranted.

4. "By Report": When the value of a procedure is to be determined "By Report", information concerning

the nature, extent and need for the procedure or service, the time, the skill, and the equipment necessary, etc., is to be furnished. A detailed clinical record is NOT necessary.

5. "INDEPENDENT PROCEDURE": Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "Independent procedure" is applicable.

6. Values for mileage, night calls, preparation of special reports, etc., are listed under "Other Services" in this section (Items 9070–9075).

7. Necessary drugs, supplies and materials provided by the physician may be charged for separately.

8. Values for other diagnostic, therapeutic, surgical, anesthesia, x-ray and laboratory procedures are listed in the sections entitled "Surgery," "Anesthesia," "Radiology," and "Laboratory."

MEDICINE

OFFICE VISITS

Those services performed by a physician in his own office, or in an out-patient facility of a hospital, such as an out-patient clinic, examining or treatment room, etc. See 90500–90570 for emergency care.

NEW PATIENT

90000	Brief evaluation, history, examination and/or treatment	$27.00
90010	Initial limited history and examination, including initiation of diagnostic and treatment program	45.00

90015	Initial intermediate history and examination, including initiation of diagnostic and treatment program	60.00
90020	Initial comprehensive history and examination, including initiation of diagnostic and treatment program	80.00

ESTABLISHED PATIENT

90030	Minimal service — injection, minimal dressing, blood pressure or weight check	13.00
90040	Brief examination, evaluation and/or treatment	18.00
90050	Limited examination, evaluation and/or treatment	23.00
90060	Intermediate examination, evaluation and/or treatment	30.00
90070	Extended re-examination and/or re-evaluation	40.00
90080	Comprehensive re-examination and/or re-evaluation	60.00
90085	Comprehensive re-examination or re-evaluation when complicated by chronically disabling condition	72.00

HOME VISITS

90110	Initial limited history and examination, including initiation of diagnostic and treatment program	50.00
90115	Initial intermediate history and examination, including initiation of diagnostic and treatment program	50.00

90120	Initial comprehensive history and examination including initiation of diagnostic and treatment program	50.00

HOME VISITS; HOSPITAL VISITS; CRITICAL CARE SERVICES

ESTABLISHED PATIENT

90130	Minimal service, e.g., injection, immunization, minimal dressing, etc.	40.00
90140	Brief examination, evaluation and/or treatment, same or new illness	40.00
90150	Limited examination, evaluation, and/or treatment, same or new illness	40.00
90160	Intermediate examination, evaluation and/or treatment, same or new illness	40.00
90170	Extended re-examination or re-evaluation	40.00

(For examination, evaluation, and/or treatment, each additional resident member, use 90130)

HOSPITAL VISITS

NEW OR ESTABLISHED PATIENT
(For preoperative visits, see Surgery ground rule 1.)

90200	Initial hospital care, brief or limited history and examination, including initiation of diagnostic and treatment program and preparation of hospital records	45.00

* * *

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ANESTHESIOLOGY

BASED ON THE 1973 AMERICAN SOCIETY OF ANESTHESIOLOGY RVG USING A $16.00 CONVERSION FACTOR.

A ONE UNIT MODIFIER IS ALLOWED FOR EMERGENCY CALLS AFTER 6:00 P.M.

SURGERY

GENERAL INFORMATION AND INSTRUCTIONS

1. Values for office, home and hospital visits, consultations and other medical services, x-ray and laboratory procedures are listed in the sections entitled "Medicine," "Anesthesia," "Radiology," and "Laboratory."

2. Listed values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "Follow-up Days." Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. Where the follow-up period is listed as zero (0) and the item is preceded by an asterisk (*), see (3) below.

3. ASTERISK (*): Where an asterisk (*) precedes a procedure number and its value, the following rules apply:

(a) The listed value is for the SURGICAL PROCEDURE ONLY.

(b) ALL POST-OPERATIVE CARE is to be ADDED on a fee-for-service basis.

(c) When such a procedure requires hospital admission, an additional two (2) units are to be added to the listed value to cover the additional services required. (Items 9020, 9021 or 9022 are not to be used in addition.)

(d) When such a procedure is carried out at the time of the initial visit, an additional one (1) unit is to be added to the listed value in lieu of item 9001, etc.

3. "Sv." ITEMS: "Sv." in the value column indicates that the value is to be calculated as the sum of the various services rendered (e.g., hospital visit, etc.) according to the ground rules covering those services.

4. "BY REPORT": When the value of a procedure is to be determined "by report," the following information may be required:

(a) Diagnosis (post-operative).
(b) Size, location and number of lesion(s) or procedure(s) where appropriate.
(c) Major surgical procedure and supplementary procedure(s).
(d) Whenever possible, list the nearest similar procedure by number according to these studies.
(e) Estimated follow-up period.
(f) Operative time.

COMPLICATIONS or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis.

When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

INDEPENDENT PROCEDURE: Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a *separate entity*, not immediately related to other ser-

vices, the indicated value for "Independent Procedure" is applicable.

MULTIPLE SURGICAL PROCEDURES:

(a) When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified in this Study.

(b) When an incidental procedure, (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the value will be that of the major procedure only.

PROCEDURES NOT SPECIFICALLY LISTED will be given values comparable to those of the listed procedures of closest similarity.

When warranted by the necessity of SUPPLEMENTAL SKILLS, values for services rendered by two or more physicians will be allowed.

When the SKILLS OF TWO SURGEONS are required in the management of a specific surgical procedure, by prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. The value may be increased by 25 per cent under these circumstances.

1. INJECTION PROCEDURES in conjunction with radiological service(s) include necessary local anesthesia, placement of needle or catheter and injection of contract media. (See also Rule 7, page 53.)

1. NECESSARY DRUGS, materials and supplies *provided by the physician* may be charged for separately.

	SURGICAL ASSISTANTS	Value
80	Assist at surgery, 20% of listed unit value(s) of surgical procedure(s)	
81	minimum allowance	85.00

			Follow-Up Days
	INTEGUMENTARY SYSTEM		
	SKIN, MUCOUS MEMBRANE, AND SUBCUTANEOUS TISSUES		
	INCISION		
*10000	Incision and drainage of infected or non-infected sebaceous cyst, one lesion	12.00	0
10001	second lesion	6.00	
10002	over two, each additional lesion	4.00	
*10003	Incision and drainage of infected or non-infected epithelial inclusion cyst ("sebaceous cyst") with complete removal of sac and treatment of cavity	40.00	0
	(For excision, see 11400 et seq.)		
*10020	Incision and drainage of furuncle	12.00	0
*10040	Acne surgery (e.g., marsupialization, opening, or removal of multiple milia, comedones, cysts, pustules)	17.00	0
*10060	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradentis and other cutaneous or subcutaneous abscesses), simple	21.00	0
*10080	Drainage of pilonidal cyst, simple	21.00	0

(For excision of pilonidal cyst, see 11770, 11771, 11772)

*10100	Drainage of onychia or paronychia	21.00 0
*10120	Incision and removal of foreign body, subcutaneous tissues, simple	21.00 0
*10140	Drainage of hematoma, simple	21.00 0
*10160	Puncture aspiration of abscess, hematoma, or cyst	12.00 0

EXCISION

DEBRIDEMENT

(For dermabrasions, see 15780–15800)

(For nail debridement, see 11700–11711)

(For burn(s), see 16000–16030)

DEBRIDEMENT (cont.)

*11000	Debridement of extensively eczematous or infected skin up to 10% of the body surface	21.00 0
11001	for each additional 10% of the body surface	8.00
11040	Debridement of abrasions	17.00 0

PARING OR CURETTEMENT

*11050	Paring or curettement of a benign lesion with or without chemical cauterization (such as verrucae or clavi), single lesion	21.00 0
11051	each additional four or less	8.00
11052	all additional lesions	8.00

EXCISION AND SIMPLE CLOSURE

(Not reconstructive surgery; for reconstructive surgery, see "Repair-Complex")

11100	Biopsy of skin or subcutaneous tissue (including simple closure), unless otherwise listed (independent procedure)	34.00 7
11101	each additional lesion	17.00

* * *

RADIOLOGY

X-RAY — DIAGNOSTIC

GENERAL INFORMATION AND INSTRUCTIONS

1. Values include usual contrast media, equipment and materials. An additional charge may be warranted when special surgical trays and materials are provided by the physician.

2. Values include consultation and written report to the referring physician.

3. When x-ray examinations are made in conjunction with other medical services at the same visit, and by the same physician, values for each x-ray examination will be reduced by 0.5 units unless otherwise specified.

4. When multiple x-ray examinations are made at the same visit and without concomitant other services, values for each examination except the major examination will be reduced 0.5 units unless otherwise specified in this Study.

5. When progress examinations of the same part and for the same illness are made within twenty-four (24) hours, the value of the secondary examination will be reduced by 0.5 units, unless otherwise specified in this Study.

6. Values for bedside, home or operating room examinations (unless otherwise indicated) are listed under Miscellaneous Studies, 7476 and 7477.

7. For procedures marked by a small black star (*), the injection procedure (i.e., necessary local anesthesia, placement of needle or catheter and injection of contrast media) is *not* included in the unit value. For procedures not marked with a small black star(*) the injection procedure by the radiologist is included in the unit value.

DIAGNOSTIC RADIOLOGY

		PC	TOTAL
	HEAD AND NECK		
70002	Pneumoencephalography, supervision and interpretation only	69.30	177.30
70003	complete procedure	189.00	295.50
70010	Myelography, posterior fossa, supervision and interpretation only	63.00	147.75
70011	complete procedure	119.70	206.85
70015	Cisternography, positive contrast, supervision and interpretation only	63.00	147.75
70016	complete procedure	119.70	206.85
70020	Ventriculography, air contrast, supervision and interpretation only	59.00	133.85
70021	positive contrast, supervision and interpretation only	59.00	133.85

70022	Stereotactic localization, head	81.90	177.30
70030	Eye, for foreign body	16.80	39.40
70040	for localization of foreign body (70030 not included)	33.60	68.95
70050	combined 70030 and 70040	42.00	88.65
70100	Mandible, partial, less than four views	12.60	29.55
70110	complete, minimum of four views	21.00	49.25
70120	Mastoids, less than three views per side	16.80	39.40
70130	complete, minimum of three views	25.20	59.10
70134	Internal auditory meati, complete	25.20	59.10
70140	Facial bones, less than three views	12.60	29.55
70150	complete, minimum of three views	21.00	49.25
70160	Nasal bones, complete, minimum of three views	12.60	29.55
70170	Nasolacrimal duct (dacryocystography) supervision and interpretation only	16.80	39.40
70171	complete procedure	48.30	68.95
70190	Optic Foramina	12.60	29.55
70200	Orbits, complete, minimum of four views	21.00	49.25
70210	Sinuses, paranasal, less than three views	12.60	29.55

70220	complete, minimum of three views	21.00	49.55
70230	contrast studies, in addition to 70220, supervision and interpretation only	18.90	49.55
70231	contrast studies, in addition to 70220, complete procedure	100.80	118.20
70240	Sella Turcica	16.80	39.40
70250	Skull, less than four views, with or without stereo	12.60	29.55
70260	complete, minimum of four views, with or without stereo	21.00	49.25

* * *

PATHOLOGY GROUND RULES

GENERAL INFORMATION AND INSTRUCTIONS

1. UNUSUAL SERVICE OR PROCEDURE: A service may necessitate skills and time of the physician over and above listed services and values. If substantial "by report" additional values may be warranted. (See modifier — 22)

2. UNLISTED SERVICE OR PROCEDURE: Identify as 99200. When an unlisted service or procedure is provided, the values used should be substantiated "by report." (See rule 4 below.)

3. BY REPORT ("BR") ITEMS: BR in the value column indicates that the value of this service is to be determined "by report," because the service is too unusual, variable or new to be assigned a unit value. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equip-

ment necessary, etc., is to be furnished. A detailed clinical record is not necessary.

4. MATERIALS SUPPLIED BY PHYSICIAN: Identify as 99070. Supplies and materials provided by the physician (e.g., sterile trays, drugs, etc.) over and above those usually included with the office visit or other services rendered may be charged for separately. (List drugs, trays, materials or supplies provided.)

5. PANEL (PROFILE) TESTS: Panel (profile) tests are defined as certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple tests performed on an "individual," "immediate" or "stat" reporting basis.

6. MISCELLANEOUS: Values for office, home, and hospital visits, consultations and other medical services, X-ray, anesthesia and surgical procedures are listed in the sections entitled MEDICINE, ANESTHESIA, SURGERY and RADIOLOGY and NUCLEAR MEDICINE.

Automated, Multichannel Tests; Urinalysis; Chemistry & Toxicology

PATHOLOGY

AUTOMATED, MULTICHANNEL TESTS

The following list contains those tests which can be and are frequently done as groups and combinations on automated multichannel equipment. The unit values apply when three or more of these tests are ordered per patient visit. For reporting two tests, regardless of method of testing, use appropriate single test code numbers. Collection and handling is not included.

Albumin
Bilirubin, direct

Bilirubin, total
Calcium
Carbon dioxide content
Chlorides
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase
Phosphatase, alkaline
Phosphorus
Potassium
Protein, total
Sodium
Transaminase, glutamic oxalacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen
Uric acid

80104	Any three or four tests	15.00
80105	Any five tests	15.75
80106	Any six tests	16.50
80112	Any seven through twelve tests	19.50
80116	Any thirteen through sixteen tests	22.50
80118	Any seventeen or eighteen tests	25.50
80119	Over eighteen tests (indicate instrument used and number of tests performed)	RNE[degrees]

URINALYSIS

(For specific analyses, see appropriate section)

81000 (When combined with CBC, see 89005–89007 for reporting)

81000	Urinalysis, routine, complete (chemical and microscopic)	6.00
81005	chemical, qualitative, any number of constituents	4.00
81010	concentration and dilution test	7.00
81015	microscopic only	4.00
81016	microscopic when done in conjunction with 81005	2.00
81020	two or three glass test	7.00
81030	Quantitative sediment analysis and quantitative protein (Addis count)	12.00
81099	Unlisted urinalysis procedure	BR

CHEMISTRY AND TOXICOLOGY

Material for examination from any source, quantitative unless specified.

(APT test, see 83033)

(Acetaldehyde, blood, see volatiles 84600)

82003	Acetaminophen (Tylenol), urine	37.50

(Acetic anhydride, see volatiles, 84600)

82005	Acetoacetic acid	21.25
82009	Acetone, qualitative	6.00
82010	quantitative	17.00

* * *

APPENDIX C

Comparisons of Changes in Average Conversion Factors and Consumer Price Indices

	Average Conversion Factor: Maricopa Foundation	National Consumer Price Index for "Physicians' Services"[4]	National Index for "Medical Care"[4]
1978	10.40[1]	223.1	219.4
1973	7.62[2]	138.2	137.7
Difference	2.78	84.9	81.7
Average Annual Change	7.3%	12.3%	11.9%
1978	10.40	223.1	219.4
1970	6.63[3]	121.4	120.6
Difference	3.77	101.7	98.8
Average Annual Change	7.1%	10.5%	10.2%

[1]J.A. 268 ¶ 304.

[2]J.A. 211 ¶ 94.

[3]J.A. 210 ¶ 93.

[4]United States Bureau of the Census, *Statistical Abstract of the United States: 1980* (1981) at 486-87 (1967 = "100").

[5]Hogan & Armstrong, *Consumer Prices: A Record Increase in 1980*, 28 Ariz. Bus. (March 1981) 3 at 10-11 (1969 = "100").

Appendix C-2

National Index for "All Items"[4]	Metropolitan Phoenix Index for "All Items"[5]	Metropolitan Phoenix Index for "Medical Care"[5]
195.4	171.0	179.5
133.1	120.8	165.2
62.3	50.2	14.3
9.4%	8.3%	1.7%
195.4	171.0	179.5
116.3	104.2	133.2
79.1	66.8	46.3
8.5%	8.0%	4.3%